2012 Medicare Part C Plan Reporting Requirements
Technical Specifications Document

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The Center for Medicare

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BACKGROUND AND INTRODUCTION

CMS has authority to establish reporting requirements for Medicare Advantage Organizations (MAOs) as described in 42CFR §422.516 (a). Pursuant to that authority, each MAO must have an effective procedure to develop, compile, evaluate, and report information to CMS in the time and manner that CMS requires. Additional regulatory support for the Medicare Part C Reporting Requirements is also found in the Final Rule entitled "Medicare Program; Revisions to the Medicare Advantage and Prescription Drug Program" (CMS 4131-F), and in the interim final rule (CMS 4138-IFC).

This document provides a description of the measures, reporting timeframes and deadlines, and specific data elements for each measure. The 2012-2014 Part C Reporting Requirements document completed OMB review and approval (12/20/2011) in compliance with the Paperwork Reduction Act of 1995; OMB control number is 0938-0008.

The technical specifications contained in this document should be used to develop a common understanding of the data, to assist organizations in preparing and submitting datasets, to ensure a high level of accuracy in the data reported to CMS, and to reduce the need for organizations to correct and resubmit data.

Each Part C Reporting Requirement measure of this document has the following information presented in a standardized way for ease of use:

A. Data element definitions - details for each data element reported to CMS,

B. Notes - additional clarifications to a reporting section derived from the responses to comments received under the OMB clearance process.

C. Reminder: Underlined passages indicate updates, and/or new information.

GENERAL INFORMATION

Organizations for which these specifications apply are required to collect these data.
Reporting will vary depending on the plan type and measure. Some measures will be reported annually, while others will be reported quarterly.
Reporting Part C Data: The information here should be used (unless otherwise indicated, or instructed by CMS) for reporting these measures from this point forward.

Special characters (#@ %^"+") are not permitted when entering data.

The Employer Name field is 150 characters in length; if the name is longer, we ask that you abbreviate to the best of your ability.
The following data elements listed directly below are considered proprietary, and CMS considers these as not subject to public disclosure under provisions of the Freedom of Information Act (FOIA):*

- Per service costs in the benefit utilization measure (Benefit Utilization)—This measure is now suspended. Employer DBA and Legal Name, Employer Address, Employer Tax Identification Numbers (Employer Group Sponsors)

*Under FOIA, Plans may need to independently provide justification for protecting these data if a FOIA request is submitted.

In order to provide guidance to Part C sponsors on the actual process of entering reporting requirements data into the Health Plan Management System, a separate Health Plan Management System (HPMS) Plan Reporting Module (PRM) User Guide may be found on the PRM start page.

Exclusions from Reporting

National PACE plans and 1833 cost plans are excluded from reporting all Part C Reporting Requirements measures.

Suspended from Reporting:

Measure # 1 *Benefit Utilization*;
Measure #10 *Agent Compensation Structure*; and
Measure #11 *Agent Training and Testing* is suspended.

New Reporting:

Measure # 14 Enrollment Disenrollment

Timely Submission of Data

Data submissions are due by 11:59 p.m. Pacific time on the date of the reporting deadline. CMS expects that data are accurate on the date they are submitted. Data submitted after the given reporting period deadline shall be considered late and may not be incorporated within CMS data analyses and reporting. Only data reflecting a good faith effort by an organization to provide accurate responses to Part C reporting requirements will be counted as data submitted in a timely manner.

If a plan terminates before or at the end of its contract year (CY), it is not required to report and/or have its data validated for that CY.

Organizations failing to submit data, or submitting data late and/or inaccurately will receive compliance notices from CMS.

Correction of Previously Submitted Data / Resubmission Requests

CMS expects organizations to promptly correct all previously submitted data if it is later determined that the data were erroneous. Corrections of previously submitted data are appropriate if they are due to an error made at the date of the original submission, or as otherwise indicated by CMS.

- Organizations are **not required** to update previously submitted data as a result of subsequent information received (by the organization) after the reporting deadline for the section at issue.
- Once a reporting deadline has passed, organizations that need to correct data must submit a formal request to resubmit data via the HPMS Plan Reporting Module.
- Resubmission requests may only be submitted after the original reporting deadline has expired.

If previously submitted data are incorrect, Part C Sponsors should request the opportunity to correct and resubmit data. Part C Sponsors are not responsible for updating previously submitted measures in which CMS expects Part C Sponsors to receive reconciled data. Part C Sponsors are, however, responsible for correcting previously submitted data if it is determined the data were erroneous. In order to accommodate data validation activities, data corrections may only be submitted until March 31st following the last quarter or end of year reporting deadline. CMS reserves the right to establish deadlines after which no further corrections may be submitted.

Detailed instructions on resubmissions may be found on the starter page of the HPMS Plan Reporting Module User Guide.

Due Date Extension Requests

Generally speaking, CMS does not grant extensions to reporting deadlines, as these have been established and published well in advance. It is our expectation that organizations do their best with the information provided in the most current version of the Technical Specifications to prepare the data to be submitted in a timely f[as]hion. Any assumptions that organizations may make in order to submit data timely should be fully documented and defensible under audit. CMS will consider appropriate "Resubmission Requests" through the Plan Reporting Module (PRM).

Periodic Updates to the Technical Specifications

If CMS changes the technical specifications during the contract year, which requires a change in reporting methodology, CMS is requiring that reports be regenerated for the prior reporting periods for Part C reporting beginning for CY 2012.

CMS has established the following email address for the purpose of collecting all questions regarding the Part C Technical Specifications: PartCplanreporting@cms.hhs.gov. Plans should be aware that immediate responses to individual questions may not always be possible given the volume of email this box receives. CMS recommends that plans first refer to the current Medicare Part C Reporting Requirements Technical Specifications for answers or, when appropriate, contact the HPMS help desk: 1-800-220-2028 or email: hpms@cms.hhs.gov .

Reporting Requirement Measures List

The following summary table provides an overview of the parameters around each of the current Part C reporting requirements measures.

Measure	Organization Types Required to Report	Report Freq./ Level	Report Period (s)	Data Due date (s)
1. Benefit Utilization		Suspended		
2. Procedure Frequency	CCP, PFFS, Demo, MSA (includes all 800 series plans), Employer/Union Direct Contract	1/year Contract	1/1-12/31	5/31 of following year
3. Serious Reportable Adverse Events	CCP, PFFS, Demo, MSA (includes all 800 series plans) , Employer/Union Direct Contract	1/year Contract	1/1-12/31	5/31 of following year
4. Provider Network Adequacy	CCP, 1876 Cost, Demo (includes all 800 series plans)	1/year Contract	1/1 - 12/31	2/28 of following year
5. Grievances	CCP, PFFS, 1876 Cost, Demo, MSA (includes all 800 series plans) , Employer/Union Direct Contract	4/Year PBP	1/1-3/31 4/1-6/30 7/1-9/30 10/1-12/31	5/31 8/31 11/30 2/28 of following year
6. Organization Determinations/ Reconsiderations	CCP, PFFS, 1876 Cost, Demo, MSA (includes all 800 series plans) , Employer/Union Direct Contract	4/Year Contract	1/1-3/31 4/1-6/30 7/1-9/30 10/1-12/31	5/31 8/31 11/30 2/28 of following year

7. Employer Group Plan Sponsors	CCP, PFFS, 1876 Cost, Demo, MSA (includes 800 series plans and any individual plans sold to employer groups), Employer/Union Direct Contract	1/year PBP	1/1 - 12/31	2/28 of following year
8. PFFS Plan Enrollment Verification Calls	PFFS (800-series plans should NOT report)	1/year PBP	1/1-12/31	2/28 of following year Validation unnecessary—using for monitoring only
9. PFFS Provider Payment Dispute Resolution Process	PFFS (includes all 800 series plans), Employer/Union Direct Contract	1/year PBP	1/1-12/31	2/28 of following year Validation unnecessary—using for monitoring only
10. Agent Compensation Structure		Suspended		
11. Agent Training and Testing		Suspended		
12. Plan Oversight of Agents	CCP, PFFS, 1876, Cost, Demo, MSA	1/Year Contract	1/1 – 12/31	2/28 of the following year
13. Special Need Plans (SNP) Care Management	Local, CCP, Demo, Regional CCP,RFB Local CCP with SNPs	1/Year PBP	1/1-12/31	5/31 of following year
<u>14. Enrollment/Disenrollment</u>	<u>Stand-alone MAOs only. EGWPs and all-800 series plans are excluded. For contracts with both non-800 series and 800-series plans, data for the 800-series plan(s) may be excluded.</u>	<u>4/Year Contract</u>	<u>1/1-3/31 4/1-6/30 7/1-9/30 10/1-12/31</u>	<u>5/31 8/31 11/30 2/28 of following year</u>

Measures

1. BENEFIT UTILIZATION (SUSPENDED)

2. PROCEDURE FREQUENCY

Measure	Organization Types Required to Report	Report Freq./ Level	Report Period (s)	Data Due date (s)
2. Procedure Frequency	01 – Local CCP 02 - MSA 03 – RFB PFFS 04 - PFFS 05 - Demo 11 – Regional CCP 14 – ED-PFFS 15 – RFB Local CCP Organizations should include all 800 series plans. Employer/Union Direct Contracts should also report this measure, regardless of organization type.	1/year Contract	1/1-12/31	5/31 of following year

Data elements reported under this measure are:

Element Number	Data Elements for Procedure Frequency Measure
2.1	Number of Enrollees receiving Cardiac Catheterization
2.2	Number of Enrollees receiving Open coronary angioplasty
2.3	Number of Enrollees receiving PTCA or Coronary Atherectomy with CABG
2.4	Number of Enrollees receiving PTCA or Coronary Atherectomy with insertion of drug-eluting coronary artery stent (s)

2.5	Number of Enrollees receiving PTCA or Coronary Atherectomy with insertion of non-drug-eluting coronary artery stent (s)
2.6	Number of Enrollees receiving PTCA or Coronary Atherectomy without insertion of Coronary Artery Stent
2.7	Number of Enrollees receiving Total Hip Replacement
2.8	Number of Enrollees receiving Total Knee Replacement
2.9	Number of Enrollees receiving Bone Marrow Transplant
2.10	Number of Enrollees receiving Heart Transplant
2.11	Number of Enrollees receiving Heart/Lung Transplant
2.12	Number of Enrollees receiving Kidney Transplant
2.13	Number of Enrollees receiving Liver Transplant
2.14	Number of Enrollees receiving Lung Transplant
2.15	Number of Enrollees receiving Pancreas Transplant
2.16	Number of Enrollees receiving Pancreas/Kidney Transplant
2.17	Number of Enrollees receiving CABG
2.18	Number of Enrollees receiving Gastric Bypass
2.19	Number of Enrollees receiving Excision or Destruction of Lesion or Tissue of Lung (with cancer diagnosis as specified)
2.20	Number of Enrollees receiving Excision of Large Intestine (with cancer diagnosis as specified)
2.21	Number of Enrollees receiving Mastectomy (with cancer diagnosis as specified)
2.22	Number of Enrollees receiving Lumpectomy (with cancer diagnosis as specified)
2.23	Number of Enrollees receiving Prostatectomy (with cancer diagnosis as specified)

Notes

This measure requires direct data entry into HPMS.

For each data element, plans should count the number of unique enrollees receiving the specified procedure (not the number of procedures performed) during the reporting period.

Plans should compile data from paid claims of enrollees receiving one of the above procedures.

Beginning in 2012, organizations that report similar or the same measures through HEDIS® are required to also report these measures through Part C. This represents a change in the requirements.

HEDIS® no longer reports the procedure "excision of large intestine." However, CMS is still requiring that this procedure be reported for Part C reporting requirements.

Organizations are not exempt from reporting any of these Procedure Frequency measures based on low enrollments (e.g., fewer than 1,000).

Identify the procedures by using CPT codes, ICD-9-CM procedures, ICD-9 CM diagnosis and MS-DRGs provided in Appendix 1. The expectation is that all four types of indicators need to be used singularly or in combination, keeping in mind that steps must be taken to avoid duplicate reporting when different code types are used on different claim forms. That is, one or any combination of these codes can be used if it "casts a wider net," and therefore is more likely to capture the procedure. If a diagnosis is necessary to include a procedure in this reporting, for example "prostate cancer surgery," use the ICD-9-CM diagnosis code also. For example, this would exclude reporting of a prostatectomy for benign prostatic hyperplasia (BPH).

Total Hip Replacement and Total Knee Replacement procedures have the same MS-DRGs included in Appendix 1. If a procedure is identified by MS-DRG 461-462 or 466-470 with no accompanying CPT or ICD-9 CM procedure code, and no other information is available, report "Total Knee Replacement." The table below displays "procedural precedence" given an inability to differentiate between two procedures:

Unable to differentiate between:	**Report as:**
Hip replacement vs. knee replacement	Knee replacement
Heart transplant vs. lung transplant	Heart transplant
Pancreas transplant vs. kidney transplant	Kidney transplant

We currently do not have a code for a kidney *and* liver transplant; if an enrollee undergoes a kidney and liver transplant, please code as a liver transplant. Note that bone marrow transplants do not require a cancer diagnosis. The table below demonstrates coding of Pancreas/Kidney Transplant and Heart/Lung Transplant.

Procedure	Same Admittance (Reported Element)	Different Admittance for each procedure (Reported Elements)
Pancreas/Kidney Transplant	2.16	2.15, 2.12
Heart/Lung Transplant	2.11	2.10, 2.14

Please use the most inclusive combination of procedure and diagnosis codes available in the records to assist you in determining the actual procedure that was performed when there is uncertainty. If facility billing reports one procedure and a physician another procedure and you cannot determine the correct procedure from available data, use the procedure reported by the facility.

The counts represented in each data element need not be mutually exclusive. If an enrollee received two or more of the same procedure (e.g., CABGs at different times during the reporting year), the plan should report that enrollee **only once for that data element, because the number of unique enrollees receiving that procedure, not the number of procedures, is being recorded here.**

Plans should report the number of enrollees receiving the specified procedures at the contract level.

Plans do not have to calculate a denominator, since only numbers will be reported. Report only the number of enrollees receiving the specific procedure(s) during the reporting period) that fall into each of the categories with no exclusions, unless specific exclusions are listed.

Percutaneous Transluminal Coronary [PTCA], or Balloon Angioplasty with Coronary artery bypass graft (CABG**)** surgery**,** is indicated by codes in the following range: 36.10 through 36.17 and 36.19.

For Data Elements 2.3 – 2.6: These procedures *do not* need to occur on the same date of service but *do need* to occur during the same admission.

<u>If available, plans may use 'expanded ranges' with procedure and disease codes. "Expanded ranges" refer to codes that further specify the procedure or disease.</u>

3. SERIOUS REPORTABLE ADVERSE EVENTS (SRAES)

Measure	Organization Types Required to Report	Report Freq./ Level	Report Period (s)	Data Due date (s)
3. Serious Reportable Adverse Events	01 – Local CCP 02 - MSA 03 – RFB PFFS 04 - PFFS 05 - Demo 11 – Regional CCP 14 – ED-PFFS 15 – RFB Local CCP Organizations should include all 800 series plans. Employer/Union Direct Contracts should also report this measure, regardless of organization type.	1/year Contract	1/1-12/31	5/31 of following year

Data elements reported under this measure are:

Element Number	Data Elements for Serious Reportable Adverse Events Measure (includes SRAEs and HACs)	Comments
3.1	Number of total surgeries	Must have occurred in acute hospital.
3.2	Number of surgeries on wrong body part	Must have occurred in acute hospital.
3.3	Number of surgeries on wrong patient	Must have occurred in acute hospital.
3.4	Number of wrong surgical procedures on a patient	Must have occurred in acute hospital.
3.5	Number of surgeries with post-operative death in normal health patient	Must have occurred in acute hospital.
3.6	Number of surgeries with foreign object left in patient after surgery	Must have occurred in acute hospital.
3.7	Number of Air Embolism events	Must have occurred in acute hospital.
3.8	Number of Blood Incompatibility events	Must have occurred in acute hospital.
3.9	Number of Stage III & IV Pressure Ulcers	Must have occurred in acute hospital.
3.10	Number of fractures	Must have occurred in acute hospital.
3.11	Number of dislocations	Must have occurred in acute hospital.
3.12	Number of intracranial injuries	Must have occurred in acute hospital.
3.13	Number of crushing injuries	Must have occurred in acute hospital.
3.14	Number of burns	Must have occurred in acute hospital.
3.15	Number of Vascular Catheter-Associated Infections	Must have occurred in acute hospital and be diagnosed during hospital stay.
3.16	Number of Catheter-Associated UTIs	Must have occurred in acute hospital and be diagnosed during hospital stay.
3.17	Number of Manifestations of Poor Glycemic Control	Must have occurred in acute hospital and be diagnosed during hospital stay.

3.18	Number of SSI (Mediastinitis) after CABG	30-day inclusion period following discharge. Data for the CC/MCC code to be found from hospital claims only.
3.19	Number of SSI after certain Orthopedic Procedures	365-day inclusion period following discharge. Data for the CC/MCC code to be found from hospital claims only.
3.20	Number of SSI following Bariatric Surgery for Obesity	30-day inclusion period following discharge. Data for the CC/MCC code to be found from hospital claims only. .
3.21	Number of DVT and pulmonary embolism following certain orthopedic procedures	Must have occurred in acute hospital and be diagnosed during hospital stay.

Notes

This measure requires direct data entry into HPMS.

See Appendix 2 for the codes to identify Serious Reportable Adverse Events (SRAE). Some SRAEs do not have codes, but these events are so egregious and rare that the hospitals should be able to report them to the plans. Plans should use both primary and secondary diagnosis and procedure code fields to identify the event.

Note: Any patient **admitted with** an SRAE and/or hospital acquired condition (HACs) is to be excluded from this measure. CMS reminds reporters that only those acute care inpatients who suffer SRAEs and/or HACs **after** admission, during their hospital stay, should be included in this measure. **Generally**, t**he Present on Admission (POA) indicator must be 'N,' for 'No,' for a condition to be counted as a hospital-acquired condition. However, data elements 3.18, 3.19, and 3.20 are exceptions to this since they involve SRAEs/HACs with long inclusion periods. If a beneficiary has a SRAE/HAC that resulted from a previous hospitalization and is readmitted, either as a result of that SRAE/HAC and/or for other reasons, the POA indicator could be "Y" and the SRAE/HAC should still be counted.**

Data elements 3.15 – 3.17 and 3.21 must have occurred during the stay. 3.18-3.20 have follow-up periods that are specified in the measure; data for the CC/MCC code to be found from hospital claims only (i.e., same hospital claim with the procedure and/or subsequent hospital claim).

SRAE and/or HACs acquired after admission to Long Term Acute Care facilities should not be counted for this measure (see below).

Organizations are required to report on these events and are also required to differentiate among the three possibilities listed: surgery on wrong body part, surgery on wrong patient, and wrong

surgical procedures on a patient. These are egregious events that could require some plan follow-up with the hospitals involved.

For purposes of the Part C reporting requirements, plans should be reporting SRAE data consistent with the current CMS hospital reporting requirements unless those requirements conflict with these technical specifications. In most, if not all cases, plans will be receiving the SRAE data from hospitals; therefore, this should not ordinarily present a problem with reporting requirements.

An SRAE report should be pulled by date of service, and any re-run done as close as possible to the reporting date. However, if a report by date of service is not practical or possible then a report by discharge date is acceptable.

Plans should report the number of surgeries occurring only in acute inpatient hospital settings.

A single episode cannot count in more than one category unless multiple SRAEs and/or HACs occur during that single episode.

For purposes of this measure, you may use ASA 1 to identify a person of normal health. For determining an ASA category #1 patient, CMS recommends following-up with the hospital to obtain the documentation from the medical record. SRAEs are rare, and CMS believes hospitals should be able to report them to plans outside of an automated information system if no such system captures these events.

All claims for this measure are based on incurred date.

All SRAEs and hospital acquired conditions (HACs) are mutually exclusive. If a claim has a code for a hip replacement and knee replacement, the SRAE or HAC would count for both--one SRAE or HAC associated with the hip replacement, and one associated with the knee replacement.

Surgical Site Infection (SSI) (Mediastinitis) after CABG (Data Element 3.18)

For the SSI (Mediastinitis) after CABG event, the diagnosis code and the procedure code may be on different claims. If they are on different claims, they do not need to be on for the same date of service to be counted for this measure.

The inclusion period for dates of service should extend 30 days from discharge.

SSI after certain Orthopedic Procedures Data Element 3.19

After certain orthopedic procedures events, the diagnosis code and the procedure code may be on different claims, and do not have to occur on the same date of service. The inclusion period should extend 365 days after discharge.

SSI following Bariatric Surgery (Data Element 3.20)

For the SSI following bariatric surgery for obesity events, the diagnosis code and the procedure code may be on different claims, and may be on the same date of service. The inclusion period should extend 30 days after discharge.

Additional Guidance:

Adverse health conditions present upon admission should be excluded from this measure.
For surgical site infection hospital-acquired conditions (HACs) the diagnosis code and procedure may be on the same claim, or on different claims.

Plans should only use paid claims for the SRAE measure.

Exception: Denied claims should be included if they are not reimbursable by CMS such as "Never Events" or HACs.

It is not necessary for an SRAE claim to contain *every* qualifier to be counted for this measure. For example, Vascular-Catheter Associated Infections (Data Element 3.15) does not need an ICD9(Dx), ICD9(procedure), CPT and DRG on a claim. One of these code types (as specified in Appendices 4 and 5) is sufficient to identify a claim as an SRAE.

Plans may map their non-standard or homegrown codes to those codes provided in Appendix 1 as necessary for identification of procedures associated with any SRAEs or HACs. Plans may also map SRAE and HACs that are typically documented by Hospital Review personnel to codes in Appendix 2 as necessary.

If an SRAE is reported on a claim and there in an "N" (N= no) in the Present on Admission (POA) field, this is considered a "confirmation" that the SRAE was acquired during the hospital stay.

Location(s) of an ulcer on a patient is unimportant for this measure, it is only important to note that an ulcer(s) did not present on admission (POA).

For this measure, an 'episode' is defined as an interval of health care occurring in an acute care hospital care facility for a specific medical problem or condition. It consists of the period between admission and discharge or observation followed by admission and then discharge from the acute care hospital.

If an episode falls into more than one element, count all elements. For example, if a burn was followed by a crushing injury, report **both** the burn and the crushing injury.

For those instances where a member incurs multiple SRAEs or HACs associated with multiple procedures, report the SRAEs or HACs associated with all those procedures.

If available, plans may use 'expanded ranges' with procedure and disease codes. "Expanded ranges" refer to codes that further specify the procedure or disease.
Other Categorizations of SRAEs:

Categorize as follows:

SRAE	Categorize as
Effects of reduced temperature	Burns
Effects of heat/light	Burns
Effects of air pressure	Crushing Injuries
Other external causes	Crushing Injuries

4. PROVIDER NETWORK ADEQUACY

Measure	Organization Types Required to Report	Report Freq./ Level	Report Period (s)	Data Due date (s)
4. Provider Network Adequacy	01 – Local CCP 05 - Demo 06 – 1876 Cost 11 – Regional CCP 15 – RFB Local CCP Organizations should include all 800 series plans.	1/year Contract	1/1 - 12/31	2/28 of following year

Data elements reported under this measure are:

Element Number	Data Elements for Provider Network Adequacy Measure
4.1 – 4.6	Number of PCPs in network on first day of reporting period by PCP type - General Medicine (4.1), Family Medicine (4.2), Internal Medicine (4.3), Obstetricians (4.4), Pediatricians (4.5), State Licensed Nurse Practitioners (4.6)
4.7 – 4.12	Number of PCPs in network continuously through reporting period by PCP type - General Medicine (4.7), Family Medicine (4.8), Internal Medicine (4.9), Obstetricians (4.10), Pediatricians (4.11), State Licensed Nurse Practitioners (4.12)
4.13 – 4.18	Number of PCPs added to network during reporting period by PCP type - General Medicine (4.13), Family Medicine (4.14), Internal Medicine (4.15), Obstetricians (4.16), Pediatricians (4.17), State Licensed Nurse Practitioners (4.18)
4.19 – 4.24	Number of PCPs accepting new patients at start of reporting period by PCP type - General Medicine (4.19), Family Medicine (4.20), Internal Medicine (4.21), Obstetricians (4.22), Pediatricians (4.23), State Licensed Nurse Practitioners (4.24)
4.25 – 4.30	Number of PCPs accepting new patients at end of reporting period by PCP type - General Medicine (4.25), Family Medicine (4.26), Internal Medicine (4.27), Obstetricians (4.28), Pediatricians (4.29), State Licensed Nurse Practitioners (4.30)
4.31 – 4.36	Number of PCPs in network on last day of reporting period by PCP type - General Medicine (4.31), Family Medicine (4.32), Internal Medicine (4.33), Obstetricians (4.34), Pediatricians (4.35), State Licensed Nurse Practitioners (4.36)
4.37 – 4.46	Number of specialists/facilities in network on first day of reporting period by specialist/facility type – Hospitals (4.37), Home Health Agencies (4.38), Cardiologist (4.39), Oncologist (4.40), Pulmonologist (4.41), Endocrinologist (4.42), Skilled Nursing Facilities (4.43), Rheumatologist (4.44), Ophthalmologist (4.45), Urologist (4.46)
4.47 – 4.56	Number of specialists in network continuously through reporting period by specialist/facility type– Hospitals (4.47), Home Health Agencies (4.48), Cardiologist (4.49), Oncologist (4.50), Pulmonologist (4.51), Endocrinologist (4.52), Skilled Nursing Facilities (4.53), Rheumatologist (4.54), Ophthalmologist (4.55), Urologist (4.56)
4.57 – 4.66	Number of specialists added during reporting period by specialist/facility type - Hospitals (4.57), Home Health Agencies (4.58), Cardiologist (4.59), Oncologist (4.60), Pulmonologist (4.61), Endocrinologist (4.62), Skilled Nursing Facilities (4.63), Rheumatologist (4.64), Ophthalmologist (4.65), Urologist (4.66)
4.67 – 4.76	Number of specialists accepting new patients at start of reporting period by specialist/facility type- Hospitals (4.67), Home Health Agencies (4.68), Cardiologist (4.69), Oncologist (4.70), Pulmonologist (4.71), Endocrinologist (4.72), Skilled Nursing Facilities (4.73),

	Rheumatologist (4.74), Ophthalmologist (4.75), Urologist (4.76)
4.77 – 4.86	Number of specialists accepting new patients at end of reporting period by specialist/facility type - Hospitals (4.77), Home Health Agencies (4.78), Cardiologist (4.79), Oncologist (4.80), Pulmonologist (4.81), Endocrinologist (4.82), Skilled Nursing Facilities (4.83), Rheumatologist (4.84), Ophthalmologist (4.85), Urologist (4.86)
4.87 – 4.96	Number of specialists in network on last day of reporting period by specialist/facility type- Hospitals (4.87), Home Health Agencies (4.88), Cardiologist (4.89), Oncologist (4.90), Pulmonologist (4.91), Endocrinologist (4.92), Skilled Nursing Facilities (4.93), Rheumatologist (4.94), Ophthalmologist (4.95), Urologist (4.96)

Notes

This measure requires direct data entry into HPMS.

Please count geriatricians as "Internal Medicine." Psychiatric Hospitals and Inpatient Substance Abuse facilities should be counted as part of a Plan's network under this measure. (This is a change from previous guidance stating that these facilities "may be counted.")

PCPs and Specialists are defined as persons. A Specialist cannot be a specialty facility, but facilities may be listed and included (e.g., SNFs and Hospitals).

Nurse practitioners include physician assistants and certified clinical nurse specialists.

Note that these provider network adequacy measures are distinct from the information on health services delivery (HSD) that is required to be provided as part of the 2012 Medicare Advantage Application. The above data elements are defined differently from the HSD elements, they are designed to address different questions, and they are required to be submitted at the contract (rather than county) level by all MAOs subject to the Part C reporting requirements.

Also, note that NCQA accreditation is independent of these reporting requirements and does not exempt an MAO from reporting these data.

The NCQA definitions for specialists and/or facilities are not necessarily the same as those listed here.

For Data Elements 4.1 - 4.36: If the plan does not recognize, for example, Obstetricians (OBs) as Primary Care Physicians (PCP), then for entry into HPMS plans should still code OBs as PCPs for the purposes of this reporting.

Data Elements 4.1 – 4.36 apply to Preferred Provider Organizations (PPO) as well.

MAOS should report their providers under all corresponding categories, regardless of whether or not they have dual specialties or are considered a PCP and a specialist.

Service is considered on-going if the provider provides continuous service in a plan's service area, even if the provider moves within the service area.

If a provider moves one office out of the service area but a second office remains, it is considered continuous service. If the provider moves out of the service area entirely (i.e., all offices move out or no offices remain), then it is not considered continuous.

If a provider continually sees plan beneficiaries at the start of the reporting period, at the end of the period, and for each month during the reporting period while remaining in the service area, this is considered continuous. For the next reporting period, the new service area would be the reference location.

Newly added providers are providers who are new to the network and/or are new to a specialty.

Report the number of providers based on their contracting date and **not** credentialing date.

Data Elements 4.37- 4.96 are intended to capture specialist and facility information separately. For example, Data Elements 4.37- 4.46 should include the number of specialists or facilities in network on the first day of the reporting period. The specialists to be reported include: cardiologists, oncologists, pulmonologists, endocrinologists, rheumatologists, ophthalmologists, and urologists. The facilities to be reported include: hospitals, home health agencies, and skilled nursing facilities.

5. GRIEVANCES

Measure	Organization Types Required to Report	Report Freq./ Level	Report Period (s)	Data Due date (s)
5. Grievances	01 – Local CCP 02 - MSA 03 – RFB PFFS 04 - PFFS 05 - Demo 06 – 1876 Cost 11 – Regional CCP 14 – ED-PFFS 15 – RFB Local CCP Organizations should include all 800 series plans. Employer/Union Direct Contracts should also report this measure, regardless of organization type.	4/Year PBP	1/1-3/31 4/1-6/30 7/1-9/30 10/1-12/31	5/31 8/31 11/30 2/28 of following year

The data elements to be reported under this measure are:

Grievance Category	**Total number of Grievances**	**Number of grievances which the Sponsor provided timely notification of its decision**
No. Fraud Grievances		Does not apply to this category
Enrollment/Disenrollment		
Benefit Package Grievances		
Access Grievances		
Marketing Grievances		
Customer Service Grievances		
Privacy Issues Grievances		Does not apply to this category
Quality Of Care Grievances		
Appeals Grievances		
Other Grievances		

Notes

This measure requires direct data entry into HPMS.

For an explanation of Medicare Part C grievance procedures, refer to CMS regulations and guidance: 42 CFR Part 422, Subpart M, and Chapter 13 of the Medicare Managed Care Manual, and the CMS website: http://www.cms.gov/MMCAG/.

CMS requires plans to use one of seven categories described in this section to report grievances to CMS (Elements 5.1 – 5.7). For purposes of reporting Measure 5:

- **Grievances** are defined as those grievances completed (i.e., plan has notified enrollee of its decision) during the reporting period, regardless of when the request was received; and include grievances filed by the enrollee or his or her representative.

  Expedited grievances include complaints that involve an MAO's decision to invoke an extension in an organization determination or reconsideration; or, complaints that involve an MAO's refusal to grant a request for an expedited organization determination or reconsideration.

Reporting Inclusions:

Report:

Only those grievances processed in accordance with the plan grievance procedures outlined in 42 CFR Part 422, Subpart M (i.e., Part C grievances).

One grievance involving multiple issues under each applicable category (i.e., if an enrollee complaint alleged both marketing violations and raised concerns with plan benefits, it would be reported under Element 5.2 and Element 5.3).

Reporting Exclusions:

Do not report:

Enrollee complaints made through the CMS Complaints Tracking Module (CTM). These are addressed through a process that is separate and distinct from the plan's procedures for handling enrollee grievances. Therefore, plans should not report their CTM records to CMS as their grievance logs.

Enrollee grievances processed in accordance with the grievance procedures described under 42 C.F.R., Part 423, Subpart M (i.e., Part D grievances).

Additional Guidance

- If an enrollee files a grievance and then files a subsequent grievance on the same issue *prior to* the organization's decision or deadline for decision notification (whichever is earlier), then the issue is counted as one grievance.

- If an enrollee files a grievance and then files a subsequent grievance on the same issue *after* the organization's decision or deadline for decision notification (whichever is earlier), then the issue is counted as a separate grievance.

- For additional details concerning Measure 5 reporting requirements, see Appendix 4: *Part C Data FAQs – for Measures 5 & 6.*

6. ORGANIZATION DETERMINATIONS/RECONSIDERATIONS

Measure	Organization Types Required to Report	Report Freq./ Level	Report Period (s)	Data Due date (s)
6. Organization Determinations/ Reconsiderations	01 – Local CCP 02 - MSA 03 – RFB PFFS 04 - PFFS 05 - Demo 06 – 1876 Cost 11 – Regional CCP 14 – ED-PFFS 15 – RFB Local CCP Organizations should include all 800 series plans. Employer/Union Direct Contracts should also report this measure, regardless of organization type.	4/Year Contract	1/1-3/31 4/1-6/30 7/1-9/30 10/1-12/31	5/31 8/31 11/30 2/28 of following year

Data elements reported under this measure are:

Element Number	Data Elements for Organization Determinations/Reconsiderations
6.1	Number of Organization Determinations – Fully Favorable
6.2	Number of Organization Determinations – Partially Favorable
6.3	Number of Organization Determinations – Adverse
6.4	Number of Reconsiderations – Fully Favorable
6.5	Number of Reconsiderations – Partially Favorable
6.6	Number of Reconsiderations – Adverse

Notes

This measure requires direct data entry into HPMS.

For an explanation of Part C organization determination and reconsideration procedures, refer to CMS regulations and guidance: 42 CFR Part 422, Subpart M, and Chapter 13 of the Medicare Managed Care Manual, and the CMS website: http://www.cms.gov/MMCAG/.

All plan types listed in the table at the beginning of this section are required to report: organization determinations and reconsiderations, as described in this guidance, regardless of whether the request was filed by an enrollee, the enrollee's representative, a physician or a non-contract provider who signed a Waiver of Liability.

CMS requires plans to report requests for organization determinations and reconsiderations submitted to the plan. For purposes of reporting Measure 6:

- An **organization determination** is a plan's response to a request for coverage (payment or provision) of an item or service – including auto-adjudicated claims, prior authorization requests, and requests to continue previously authorized ongoing courses of treatment. It includes requests from both contract and non-contract providers.

- A **reconsideration** is a plan's review of an adverse or partially favorable organization determination.

- A **Fully Favorable** decision means an item or service was covered in whole.

- A **Partially Favorable** decision means an item or service was partially covered (e.g., if a claim has multiple line items, some of which were paid and some of which were denied, it would be considered partially favorable; if a pre-service request for 10 therapy services was processed, but only 5 were authorized, this would be considered partially favorable).

- An **Unfavorable** decision means an item or service was denied in whole.

If a provider (e.g., a physician) declines to provide coverage an enrollee has requested or offers alternative services, the provider is making a treatment decision, not an organization determination on behalf of the plan. In this situation, the enrollee must contact the Medicare health plan to request an organization determination for the service or item in question, or the provider may request the organization determination on the enrollee's behalf.

Reporting Inclusions:

Report:

- **Completed organization determinations and reconsiderations** (i.e., plan has notified enrollee of its decision concerning a requested item or service or adjudicated a claim)

during the reporting period, regardless of when the request was received. Plans are not required to distinguish between standard and expedited organization determinations or standard and expedited reconsiderations for purposes of this reporting effort.

- **Claims with multiple line items** should be reported at the "summary level." (i.e., fully favorable, partially favorable or unfavorable).

- A **request for payment** as a separate and distinct organization determination, even if a pre-service request for that same item or service was also processed.

- A denial of Medicare payment for an item or service as either partially favorable or adverse, regardless of whether Medicaid payment ultimately is provided, in whole or in part, for that item or service.

Reporting Exclusions

Do not report:

- Dismissals or withdrawals.

- Duplicate payment requests concerning the same service or item.

- Payment requests returned to a provider/supplier in which a substantive decision (Fully Favorable, Partially Favorable or Adverse) has not been made due to error – e.g., payment requests or forms are incomplete, invalid or do not meet the requirements for a Medicare claim (e.g., due to a clerical error).

- A Quality Improvement Organization (QIO) review of an individual's request to continue Medicare-covered services (e.g., a SNF stay).

- Enrollee complaints made through the CMS Complaints Tracking Module (CTM). Plans are only to report the coverage determination or reconsideration requests as described in this section and processed in accordance with the organization determination and reconsideration procedures described under 42 C.F.R. Part 422, Subpart M.

Additional Guidance

- For additional details concerning the Measure 6 reporting requirements, see Appendix 4: *Part C Data FAQs – for Measures 5 & 6.*

7. EMPLOYER GROUP PLAN SPONSORS

Measure	Organization Types Required to Report	Report Freq./ Level	Report Period (s)	Data Due date (s)
7. Employer Group Plan Sponsors	01 – Local CCP 02 - MSA 04 - PFFS 05 - Demo 06 – 1876 Cost 11 – Regional CCP 14 – ED-PFFS Organizations should include all 800 series plans and any individual plans sold to employer groups. Employer/Union Direct Contracts should also report this measure, regardless of organization type.	1/year PBP	1/1 - 12/31	2/28 of following year

Data elements reported under this measure are:

Element Number	Data Elements for Employer Group Plan Sponsors
7.1	Employer Legal Name
7.2	Employer DBA Name
7.3	Employer Federal Tax ID
7.4	Employer Address
7.5	Type of Group Sponsor (employer, union, trustees of a fund)
7.6	Organization Type (State Government, Local Government, Publicly Traded Organization, Privately Held Corporation, Non-Profit, Church Group, Other)
7.7	Type of Contract (insured, ASO, other)
7.8	Employer Plan Year Start Date
7.9	Current Enrollment

Notes

This measure is an HPMS upload. The full record layout for this upload is available as Appendix 3 to this document.

All employer groups who have an arrangement in place with the Part C Organization for any portion of the reporting period should be included in the file upload, regardless of enrollment. For employer groups maintaining multiple addresses with your organization, please report the address from which the employer manages the human resources/health benefits.

Federal Tax ID is a required field in the file upload. Organizations should work with their employer groups to collect this information directly. Alternatively, there are several commercially available lookup services that may be used to locate this number.

Data Element 7.7 refers to the type of contract your organization holds with the employer group that binds you to offer benefits to their retirees.

For Data Element 7.8, provide the month and year when the employer group sponsor started or will start with the plan. Use the following format in coding results: MMYYYY.

Data Element 7.8, Employer Plan Year Start Date, is the month and year when the employer group sponsor began or will begin with the plan.

If an EGWP started on a non-calendar year plan and then switched to a calendar year, please use that date instead of an inception date.

For Data Element 7.9, the enrollment to be reported should be as of the last day of the reporting period and should include all enrollments from the particular employer group into the specific PBP noted. (If an employer group canceled mid-way through the reporting period, they would still appear on the listing but would show zero enrollments.)

The employer organization type is based on *how* plan sponsors file their taxes.

For organizations that provide coverage to private market employer groups and which are subject to Mandatory Insurer Reporting (MIR) of Medicare Secondary Payer data, CMS permits these organizations to use the employer address and tax ID information submitted via the MIR to also satisfy CMS' Part C reporting and validation requirements. However, this does not imply that if the organization has already submitted this information to CMS for some other purpose, they do not have to resubmit it to us again for the purposes of the Part C reporting requirements.

8. PFFS PLAN ENROLLMENT VERIFICATION CALLS; MONITORING PURPOSES ONLY

– Validation of this measure is not required because these data will be initially used only for monitoring.

Measure	Organization Types Required to Report	Report Freq./ Level	Report Period (s)	Data Due date (s)
8. PFFS Plan Enrollment Verification Calls	03 – RFB PFFS 04 – PFFS 800-series plans should **NOT** report	1/year PBP	1/1-12/31	2/28 of following year

Data elements to be reported under this measure are:

Element Number	Data Elements for PFFS Plan Enrollment Verification Calls
8.1	Number of times the plan reached the prospective enrollee with the first call of up to three required attempts in reporting period
8.2	Number of follow-up educational letters sent in reporting period
8.3	Number of enrollments in reporting period

Notes

This measure requires direct data entry into HPMS.

Note that this does not apply to group PFFS coverage. Also, this measure only pertains to calls made to individual enrollees.

Plans should tie the reported elements to enrollment effective dates. That is, for example, report for 2011 all those calls and follow-up letters linked to 2011 effective enrollments--including those done in late 2010 for 2011 enrollments. Any enrollment requests received in 2011 (for 2012 effective dates) and calls/letters associated with them would be reported in the 2012 reporting period--not in the 2011 reporting period. Otherwise, the reported elements for this measure would not connect for AEP enrollments.

9. PFFS PROVIDER PAYMENT DISPUTE RESOLUTION PROCESS; MONITORING PURPOSES ONLY

–Validation of this measure is not required because these data will initially be used only for monitoring.

Measure	Organization Types Required to Report	Report Freq./ Level	Report Period (s)	Data Due date (s)
9. PFFS Provider Payment Dispute Resolution Process	03 – RFB PFFS 04 - PFFS 14 – ED-PFFS	1/year PBP	1/1-12/31	2/28 of following year

Data elements reported under this measure are:

Element Number	Data Elements for PFFS Provider Payment Dispute Resolution Process
9.1	Number of provider payment denials overturned in favor of provider upon appeal
9.2	Number of provider payment appeals
9.3	Number of provider payment appeals resolved in greater than 60 days

Notes

This measure requires direct data entry into HPMS.

This measure must be reported by all PFFS plans, regardless of whether or not they have a network attached.

This reporting requirement seeks to capture only provider payment disputes which include any decisions where there is a dispute that the payment amount made by the MA PFFS Plan to deemed providers is less than the payment amount that would have been paid under the MA PFFS Plan's terms and conditions, or the amount paid to non-contracted providers is less than would have been paid under original Medicare (including balance billing).

10. AGENT COMPENSATION STRUCTURE – SUSPENDED

11. AGENT TRAINING AND TESTING – SUSPENDED

12. PLAN OVERSIGHT OF AGENTS

Measure	Organization Types Required to Report	Report Freq./ Level	Report Period (s)	Data Due date (s)
12. Plan Oversight of Agents	01 – Local CCP 02 - MSA 03 – RFB PFFS 04 - PFFS 05 - Demo 06 – 1876 Cost 11 – Regional CCP 15 – RFB Local CCP	1/Year Contract	1/1-12/31	2/28 of following year

Data elements reported under this measure are:

Element Number	Data Elements for Agent Oversight
12.1	Total Number of agents *
12.2	Number of agents investigated based on complaints
12.3	Number of agents receiving disciplinary actions based on complaints
12.4	Number of complaints reported to State by MAO or Cost contractor
12.5	Number of agents whose selling privileges were revoked by the plan based on conduct or discipline
12.6	Number of agent-assisted enrollments

- Record the total number of unique individual agents who were licensed to sell on behalf of the Parent Organization at any time during the reporting period.

Notes

This measure requires direct data entry into HPMS.

The "number of agents" includes only agents who were licensed to sell on behalf of the Parent Organization, either by being a direct employee or by contractual arrangement, regardless of whether the agent is actively selling during the reporting period.

If a contract does not have any licensed agents, it is appropriate to report all zeros for each element in this reporting requirement.

"Complaints" refer to both complaints from the HPMS Complaint Tracking Module (CTM) and to other complaints made directly to the MAO or Cost contractor.

If a complaint is reported to your organization that cannot be tied to a particular contract, the complaint should be reported under all contracts that the agent is licensed to sell.

A complaint could result in "disciplinary action" along a broad continuum, from manager-coaching, documented verbal warning, re-training, a documented corrective action plan, suspension, or termination of employment or contract. Any disciplinary action along this continuum would be reportable. A short term revocation (e.g., 1-2 days) is among those which CMS will require reporting. Note that disciplinary action refers to action taken by the MA plan.

For Data Element 12.2, the number of agent investigations that were completed during the reporting period should be reported, regardless of when the complaint that caused the investigation was received.

42 CFR 422.2272(d) and 42 CFR 423.2272(d) require that MA organizations (MAOs) and PDP sponsors report to the State in which the MAO or PDP sponsor appoints the agent/broker the termination of such agent/broker, including the reasons for such termination if State law so requires. 42 CFR 422.2274(e) and 42 CFR 423.2274(e) requires that MA organizations and sponsors comply with State requests for information about the performance of a licensed agent/broker as part of State investigations into that agent/brokers' conduct (with CMS establishing a Memorandum of Understanding (MOU) to share compliance and oversight information with States). Beyond this required reporting, there are no additional regulatory requirements for the reporting of complaints. Therefore, it is possible that an organization or sponsor could report a "0" for this data element.

Data Element 12.4 is intended to include only those complaints originating with the MAO that are then reported to the State.

Please report all terminations under element 12.5. Element 12.4 should include all complaints, including any that were related to a termination reported under element 1.5.

For Data Element 12.6, "Agent assisted enrollments" are defined as a count of enrollments effective during the reporting period involving a beneficiary who used the services of a licensed agent to complete the enrollment process. Examples of this include, but are not limited to: enrollments completed through a call center staffed by licensed agents, in person sales appointments, or public sales meetings where a licensed agent collects the forms.
Agent assisted enrollments include both individual and group enrollments in which a licensed agent (employee or independent) assisted in completing the enrollment process and for which that agent is compensated.

The count of agent assisted enrollments should be enrollments that are as a direct result of the participation of the group of agents reported in Data Element 12.1. The count of agent assisted enrollments should be enrollments that are as a direct result of the participation of the group of agents reported in Data Element 12.1. Plans should not include cancelled enrollments.

13. SPECIAL NEEDS PLANS (SNPS) CARE MANAGEMENT

Measure	Organization Types Required to Report	Report Freq./ Level	Report Period (s)	Data Due date (s)
13. SNPS Care Management	SNP PBPs under the following types: 01 – Local CCP 05 - Demo 11 – Regional CCP 15 – RFB Local CCP Organizations should include all 800 series plans if they are SNPs.	1/Year PBP	1/1-12/31	5/31 of following year

Data elements reported under this measure are:

Element Number	Data Elements for SNPs Care Management
13.1	Number of new enrollees
13.2	Number of enrollees eligible for an annual reassessment
13.3	Number of initial assessments performed on new enrollees during the measurement year [1]
13.4	Number of annual reassessments performed on enrollees eligible for a reassessment during the measurement year[2]

[1] The 90-day rule applies to initial health risk assessments for new enrollees and current enrollees who do not have a documented health risk assessment as of January 1st of the measurement year. The health risk assessment must be completed within 90 days of enrollment.

[2] Enrollees with documented health risk assessments must have an annual reassessment no later than one year (365 days) after their last documented health risk assessment.

Notes

This measure requires direct data entry into HPMS.

For Data Elements 13.3 and 13.4, CMS requires only **completed** assessments. This measure excludes cancelled enrollments.

Capturing the completion of initial and annual health risk assessment will be variable among MAOs offering SNPs. MAOs are required to use a standardized health risk assessment tool that may be paper-based or electronic, and may be self-developed or commercially available. The

tool must assess medical, psychosocial, functional, and cognitive needs, but CMS has not identified a standard tool that all SNPs must use. The results of the health risk assessments must be used to develop and update the required care plan for each beneficiary. MAOs are required to maintain documentation of health risk assessment. Examples of this documentation include, but are not limited to, electronic or paper copies of the completed health risk assessment tool, evidence of communication (facsimile, e-mail, letter, etc.) with providers for verification of care (reports from specialists, copies of medical records, copies of medical histories, etc.), the OASIS assessment tool for beneficiaries receiving home care, or the MDS assessment tool for beneficiaries in long-term care facilities. Designated CPT or ICD-9 Procedure codes will not capture the information.

Any one of the following types of contracts that are currently required to report: (1) Local CCP; (2) Demonstration; (3) Regional CCP; or (4) RFB Local CCP, AND offer a SNP are required to report this measure. When the member enrolls/disenrolls multiple times during a calendar year, only count this person once per year.
If a member is enrolled in CY2011, but disenrolled by 12/31/2011, then re-enrolled on 1/1/2012 (or later), count them as a "new member" for CY2012 reporting .
Eligibility records received after completion of the health assessment retroactively indicate the member was never enrolled in the plan (even when doing the HRA): do not count as a new enrollee or count the HRA.

For more information, refer to Chapter 16b of the Medicare Managed Care Manual (Section 90.8 Health Risk Assessment), which was issued and became effective on May 20, 2011.

14. ENROLLMENT AND DISENROLLMENT

CMS provides guidance for MAOs and Part D sponsors' processing of enrollment and disenrollment requests.

Both Chapter 2 of the Medicare Managed Care Manual and Chapter 3 of the Medicare Prescription Drug Manual outline the enrollment and disenrollment periods (Section 30) enrollment (Section 40) and disenrollment procedures (Section 50) for all Medicare health and prescription drug plans.

Please note: For Part C reporting, only stand-alone MAOs are to report this measure. For other organization types, please report this measure under the appropriate section in the Part D reporting requirements. For example, MA-PDs should report in Part D for this measure, listed as a "section" in Part D.

CMS will collect data on the elements for these requirements, which are otherwise not available to CMS, in order to evaluate the sponsor's processing of enrollment and disenrollment requests in accordance with CMS requirements. For example, while there are a number of factors that result in an individual's eligibility for a Special Enrollment Period (SEP), sponsors are currently unable to specify each of these factors when submitting enrollment transactions. Sponsor's

reporting of data regarding SEP reasons for which a code is not currently available will further assist CMS in ensuring sponsors are providing support to beneficiaries, while complying with CMS policies.

Data elements 1.A-1.O must include all enrollments (code 61 transactions). Disenrollments must not be included in Section 1 Enrollment.

Section 2: Disenrollment must include all voluntary disenrollment transactions.

Reporting timeline:

	Quarter 1	**Quarter 2**	**Quarter 3**	**Quarter 4**
Reporting Period	January 1 - March 31	April 1 - June 30	July 1 - September 30	October 1 - December 31
Data due to CMS/HPMS	May 31	August 31	November 30	February 28

Data elements to be entered into the HPMS at the Contract level:

1. **Enrollment:**
   - A. The total number of enrollment requests received in the specified time period.
   - B. Of the total reported in A, the number of enrollment requests complete at the time of initial receipt (i.e. required no additional information from applicant or his/her authorized representative).
   - C. Of the total reported in A, the number of enrollment requests that required requests for additional information.
   - D. Of the total reported in A, the number of enrollment requests denied due to the Sponsor's determination of the applicant's ineligibility to elect the plan (e.g. individual not having a valid enrollment period).
   - E. Of the total reported in C, the number of incomplete enrollment requests received that are completed within established timeframes.
   - F. Of the total reported in C, the number of enrollment requests denied due to the applicant or his/her authorized representative not providing information to complete the enrollment request within established timeframes.
   - G. Of the total reported in A, the number of paper enrollment requests received.
   - H. Of the total reported in A, the number of telephonic enrollment requests received (if offered).
   - I. Of the total reported in A, the number of internet enrollment requests received via plan website (if offered).
   - J. Of the total reported in A, the number of Online Enrollment Center (OEC) enrollment requests received.
   - **K. For stand-alone prescription drug plans (PDPs) only: Of the total reported in A, the number of enrollment requests effectuated by sales persons (as defined in Chapter 3 of the Medicare Managed Care Manual). (This does not apply to Part C.)**
   - L. Of the number reported in A, the number of enrollment transactions submitted using the SEP Election Period code "S" related to creditable coverage.

M. Of the number reported in A, the number of enrollment transactions submitted using the SEP Election Period code "S" related to SPAP. (This does not apply to Part C.)

N. For stand-alone prescription drug plans (PDPs) only: Of the number reported in A, the total number of enrollment transactions submitted using the SEP Election Period code "S" that coordinates with the Medicare Advantage Disenrollment Period. (This does not apply to Part C.)

O. Of the number reported in A, the number of enrollment transactions submitted using the SEP Election Period Code "S" for individuals affected by a contract nonrenewal, plan termination or service area reduction.

2. Disenrollment:

A. The total number of voluntary disenrollment requests received in the specified time period.

B. Of the total reported in A, the number of disenrollment requests complete at the time of initial receipt (i.e. required no additional information from enrollee or his/her authorized representative).

C. Of the total reported in A, the number of disenrollment requests denied by the Sponsor for any reason.

Appendix 1: Codes to Identify Procedures

Procedure Description	**CPT**	**ICD-9-CM Procedure**	**ICD-9-CM Diagnosis (applicable for cancer surgeries)**	**MS-DRG[i]**
Cardiac Catheterization	93501, 93510, 93511, 93514, 93524, 93526-93529, 93529,93530, 93531,93532, 93533,93539-93545	37.21-37.23, 88.52-88.58	n/a	216-218 222-225 233-234 286-287 (Diagnostic)
Open coronary angioplasty	35452	36.03		228, 229, 230
Percutaneous Transluminal Coronary Angioplasty (PTCA) or Coronary Atherectomy with Coronary Artery Bypass Surgery (CABG)	35472, 35481, 35491, 92982, 92984 With 33510-33514, 33516-33519, 33521-33523, 33533-33536	00.66 and a code from the following range: 36.10-36.17, 36.19.		231-232
PTCA or Coronary Atherectomy with insertion of drug-eluting coronary artery stent (s)	35472, 35481, 35491, 92982, 92984 With 92980, 92981, 92995, 92996 (doesn't differentiate stent type)	00.66 or 36.09 and 36.07		246-247

PTCA or Coronary Atherectomy with insertion of non-drug-eluting coronary artery stent (s)	35472, 35481, 35491, 92982, 92984 With 92980, 92981, 92995, 92996 (doesn't differentiate stent type)	00.66 or 36.09 and 36.06		248-249
PTCA or Coronary Atherectomy without insertion of Coronary Artery Stent	35472, 35481, 35491, 92982, 92984 With no stent	00.66, 36.09		250-251
Total Hip Replacement	27130, 27132, 27134,27137, 27138	00.70, 81.51, 81.53	n/a	461-462, 466-470
Total Knee Replacement	27446, 27447, 27486, 27487	00.80, 81.54, 81.55	n/a	461-462, 466-470
Bone Marrow Transplant	38240-38241,38242	41.00 - 41.09	201.00-201.28 201.40-201.78 201.90-201.98 203.00-203.11 203.80-203.81 204.00-204.91 205.00-205.31 205.80-205.91 206.00-206.21 206.80-206.91 207.00-207.21 207.80-207.81 208.00-208.21 208.80-208.91 238.4 238.71 238.73 – 238.76 238.79 277.39 284.01, 284.09 284.1, 284.2 284.81, 284.89 284.9	009
Heart Transplant	33945	37.51	n/a	001,002

Heart/Lung Transplant	33935	33.6	n/a	001, 002
Kidney Transplant	50360,50365, 50380,50300-50320,50547, 50340,50370, 50380	55.69	189.0, 189.1 198.0	652
Liver transplant	47135,47136	50.51, 50.59	155.0, 155.2 197.7	005, 006
Lung Transplant	32850-32854	33.50,33.51, 33.52	162.2 - 162.5 162.8, 162.9 197.0	007
Pancreas Transplant	48160,48550, 48554,48556	52.80-52.86	157.0 – 157.4 157.8, 157.9	010
Pancreas/Kidney Transplant	Pancreas transplant: 48160,48550, 48554,48556 Kidney transplant: 50360,50365, 50380,50300-50320,50547, 50340,50370	Pancreas transplant: 52.80-52.86 Kidney transplant: 55.69	157.0 – 157.4 157.8, 157.9 189.0, 189.1 198.0	008
Coronary Artery Bypass Graft (CABG)	33510-33514, 33516-33519, 33521-33523, 33533-33536	36.10-36.17, 36.19	n/a	231-236
Gastric Bypass	43846,43845, 43842, 43848,43770-43774,43659	44.31, 44.38, 44.39	n/a	619-621
Excision or Destruction of Lesion or Tissue of Lung	32440, 32442, 32445,32480, 32482,32484, 32486, 32488, 32491, 32500, 32501, 32520, 32522, 32525, 32540,32503, 32504	32.20, 32.22, 32.23 -32.26 32.28, 32.29, 32.30, 32.39, 32.41, 32.49, 32.50, 32.59 32.9	162.2 - 162.5 162.8, 162.9 197.0	163-168
Excision of Large Intestine	44141,44143-44147, 44140,44150 44160, 44204-	45.71-45.76 45.79, 45.8	153.0-153.9 197.5	374-376

	44208,4421044211,44212,44213			
Mastectomy	19180, 19182, 19200, 19220, 19240, 19300, 19301-19307	85.41-85.48	174.0-174.6, 174.8, 174.9 175.0, 175.9 198.81	582-583
Lumpectomy	19120, 19125, 19126, 19160, 19162, 19301, 19302	85.20, 85.21	174.0-174.6, 174.8, 174.9 175.0, 175.9 198.81	584-585
Prostatectomy	52601, 52612, 52614, 52620, 52630, 52640 52647, 52648, 52649,55801, 55810, 55812, 55815, 55821, 55831, 55840, 55842, 55845, 55866	60.21, 60.29, 60.3, 60.4, 60.5, 60.61, 60.62, 60.69	185, 198.82	665-667 707-708 713-714

[i] Refer to Table 5, List of Medicare Severity-Diagnosis Related Groups, found in Final rule with comments, 42 CFR Parts 411, 412, 413, and 489 [CMS–1533–FC] RIN 0938–AO70 Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates, Centers for Medicare and Medicaid Services (CMS), HHS *Federal Register*/Vol. 72, No. 162/Wednesday, August 22, 2007.

Appendix 2: Codes to Identify Serious Reportable Adverse Events

Important: The Present on Admission (POA) indicator must be 'N,' for 'No,' for a condition to be counted as a serious reportable adverse event or as a hospital-acquired condition.

Table 2: Serious Adverse Reportable Events Codes [ii]

Event Description	**CPT**	**ICD-9-CM Procedure**	**ICD-9-CM Diagnosis**	**MS-DRG**
Surgery on Wrong Body Part	n/a	n/a	E876.5 (not specific to this event)	n/a
Surgery on Wrong Patient	n/a	n/a	E876.5 (not specific to this event)	n/a
Wrong Surgical Procedures on a Patient	n/a	n/a	E876.5 (not specific to this event)	n/a
Surgery with Post-Operative Death in Normal Health Patient	ASA category 1 (a normal healthy patient).			

[ii] Refer to pages 47206—47213 42 CFR Parts 411, 412, 413, and 489 Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates; Federal Register / Vol. 72, No. 162 / Wednesday, August 22, 2007 / Rules and Regulations.

Tables 3 and 4 below lists the codes for identifying HAC data.

Table 3: Hospital Acquired Conditions (HAC) from 2008 IPPS Final Rule [iii]

Selected HAC	**CC/MCC (ICD-9-CM Codes)**
Foreign Object Retained After Surgery	998.4 (CC) 998.7 (CC)

Air Embolism	999.1 (MCC)	
Blood Incompatibility	999.6 (CC)	
Stage III & IV Pressure Ulcers	The diagnosis codes for stage III and IV Pressure Ulcers are as follows: 707.23 Pressure ulcer, stage III 707.24 Pressure ulcer, stage IV	
Falls and Trauma: -Fractures -Dislocations -Intracranial Injuries -Crushing Injuries -Burns <u>Other & Unspecified Effects of External Causes</u>	Codes within these ranges on the CC/MCC list: 800-829 (Fractures) 830-839 (Dislocations) 850-854 (Intracranial Injuries) 925-929 (Crushing Injuries) 940-949 (Burns) 991-994 (Other & Unspecified Effects of External Causes)	
Vascular Catheter-Associated Infection	999.31 (CC)	
	PLAN INQUIRIES	**CMS RESPONSES**

[iii] Refer to pages 47200—47220 42 CFR Parts 411, 412, 413, and 489 Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates; Federal Register / Vol. 72, No. 162 / Wednesday, August 22, 2007 / Rules and Regulations.

Table 4: Hospital Acquired Conditions from 2009 IPPS Rule [iv]

Selected HAC	CC/MCC (ICD-9-CM Codes)
Catheter- Associated UTI	996.64
Vascular Catheter-Associated Infection	999.31 (CC)
Manifestations of Poor Glycemic Control	250.10-250.13 (MCC)250.20-250.23 (MCC) 251.0 (CC) 249.10-249.11 (MCC) 249.20-249.21 (MCC)
Surgical Site Infection-Mediastinitis after Coronary Artery Bypass Graft (CABG)	519.2 (MCC) And one of the following procedure codes: 36.10–36.19
Surgical Site Infection Following Certain Orthopedic Procedures	996.67 (CC) 998.59 (CC) And one of the following procedure codes: 81.01-81.08, 81.23-81.24, 81.31-81.83, 81.83, 81.85
Surgical Site Infection Following Bariatric Surgery for Obesity	*Principal Diagnosis* – 278.01 998.59 (CC) and one of the following procedure codes: 44.38, 44.39, or 44.95
Deep Vein Thrombosis and Pulmonary Embolism Following Certain Orthopedic Procedures	415.11 (MCC) 415.19 (MCC) 453.40-453.42 (MCC) And one of the following procedure codes: 00.85-00.87, 81.51-81.52, or 81.54

[iv] Based on CMS-approved document (p. 240) submitted to the Office of the Federal Register (OFR) for publication. The document may vary slightly from the published document if minor editorial changes have been made during the OFR review process. Upon publication in the Federal Register, all regulations can be found at http://www.gpoaccess.gov/fr/ and at http://www.cms.hhs.gov/QuarterlyProviderUpdates/. The document published in the Federal Register is the official CMS-approved document.

Appendix 3: Employer Group Plan Sponsor Upload File Format

Required File Format = ASCII File - Tab Delimited
Do not include a header record
Filename extension should be ".TXT"
There can be multiple records per plan.

Field Name	Field Type	Field Length	Field Description	Sample Field Value(s)
Contract_ Number	CHAR Required	5 Exactly	Provide the CMS issued contract number being offered to the Employer Group Plan Sponsor. (Note: The system shall validate the contract number is valid.)	H1234
Plan_ID	NUM Required	3 Exactly	Provide the ID (with leading zeros as appropriate) of the Plan Benefit Package (PBP) being offered to the Employer Group Plan Sponsor. (Note: This is a numeric field only. The system shall validate the plan ID is valid.)	801 or 001
Employer_Legal_Name	CHAR Required	150	Provide the legal name of the Employer Group Plan Sponsor.	United Parcel Service
Employer_DBA_Name	CHAR Optional	150	If applicable provide the doing business as	United Parcel Service Employees Association

Field Name	Field Type	Field Length	Field Description	Sample Field Value(s)
			(DBA) name of the Employer Group Plan Sponsor.	
Employer_Federal_Tax_ID	NUM Required	20	Provide the federal tax ID of the Employer Group Plan Sponsor. (Note: This is a numeric field only.)	<numeric>
Employer_Street_Address	CHAR Required	150	Provide the street address of the Employer Group Plan Sponsor headquarters.	1212 North Luther Street
Employer_City_Address	CHAR Required	75	Provide the city in which the Employer Group Plan Sponsor headquarters is located.	Wichita
Employer_State_Address	CHAR Required	2	Provide the state abbreviation in which the Employer Group Plan Sponsor headquarters is located. (Note: The system shall validate the state abbreviation is appropriate.)	MO
Employer_Zip_Address	NUM Required	10	Provide the Employer Group Plan Sponsor headquarters' zip code. (Note: This is a numeric field only.)	22203
Employer_Spo	NUM	1	Indicate the Employer	1=Employer

Field Name	Field Type	Field Length	Field Description	Sample Field Value(s)
nsor_Type	Required		Group Plan Sponsor Type; acceptable values provided as sample. (Note: This is a numeric field only. The system shall validate the value is 1 through 3.)	2=Union 3=Trustees of a Fund
Employer_Organization_Type	NUM Required	1	Indicate the Employer Group Plan Organization Type; acceptable values provided as sample. (Note: This is a numeric field only. The system shall validate the value is 1 through 7.)	1=State Government 2=Local Government 3=Publicly Traded Corp. 4=Privately Held Corp. 5=Non-Profit 6=Church Group 7=Other
Employer_Contract_Type	NUM Required	1	Indicate the Employer Group Plan Contract Type; acceptable values provided as sample. (Note: This is a numeric field only. The system shall validate the value is 1 through 3.)	1=Insured 2=ASO 3=Other
Employer_Start_Date	NUM Required	6	Provide the month and year when the Employer Group Plan Sponsor started (or will start). The format is MMYYYY, so the sample is intended to	062008

Field Name	Field Type	Field Length	Field Description	Sample Field Value(s)
			depict June 2008 (062008). (Note: This is a numeric field only. The system shall validate that the month is a value of 01 to 12.)	
Employer Enrollment	NUM Required	7	Provide the current (or anticipated) enrollment for the Employer Group Plan Sponsor. (Note: This is a numeric field only. Do not include commas.)	9999999

Appendix 4: FAQs: Measures 5 & 6:

Grievances, Organization Determinations, & Reconsiderations

	PLAN INQUIRIES	CMS RESPONSES
1.	Should plans report informal complaints as Grievances under the Part C reporting requirements? For example: During the course of a home visit, a member expresses dissatisfaction regarding a particular issue. The member does not contact the plan directly to file a complaint, but the plan representative determines the member is not happy and logs the issue for Quality Improvement tracking.	Plans are to report grievances filed directly with the plan and processed in accordance with the plan grievance procedures outlined under 42 CFR Part 422, Subpart M. Plans are not to report informal complaints made to providers, as in the example provided, that are not filed with the plan.
2.	Should plans report all Dual Eligible member grievances to CMS?	No. Plans are to report Dual Eligible member grievances processed in accordance with the plan grievance procedures outlined under 42 CFR Part 422, Subpart M. For example, plans are not to report grievances filed under the state Medicaid process, but not filed with the plan.
3.	Is a plan to report a grievance, organization determination or reconsideration to CMS when the plan makes the final decision or when the request is received?	Plans are to report grievances, organization determinations and reconsiderations that were completed (i.e., plan has notified enrollee of its decision or provided or paid for a service, if applicable) during the reporting period, regardless of when the request was received.
4.	Are plans to report only those organization determinations defined under 42 C.F.R. 422.566?	CMS requires plans to report requests for payment and services, as described in the Part C Technical Specifications, Measure 6. Plans are to report a broader category of requests for payment and services than "organization determinations"

		described at 42 C.F.R. Part 422, Subpart M. For example, plans are to include adjudicated claims in the reportable data for Organization Determinations.
5.	We are seeking information on how we should report pre-service requests and claims requests for this category. Do you want Fully Favorable, Partially Favorable, and Adverse for both pre-service requests and claims requests?	Yes. Plans are to report Fully Favorable, Partially Favorable, and Adverse pre-service and claims requests (organization determinations and reconsiderations).
6.	If we have a prior authorization request and a claim for the same service -- is that considered a duplicate or should we report both?	Plans are to report **both a** prior authorization request and a claim for the same service.
7.	Is a request for a predetermination to be counted as an organization determination? Does it matter who requests the predetermination – contracted provider, non-contracted provider or member? If so, should they also be counted as partially and fully unfavorable?	Organization determinations include a request for a pre-service ("predetermination") decision, regardless of who makes the pre-service request – e.g., a contracted provider, non-contracted provider or member. Plans are to report Partially Favorable, Adverse and Fully Favorable pre-service organization determinations.
8.	Should plans report determinations made by delegated entities or only decisions that are made directly by the plan – e.g., should plans report decisions made by contracted radiology or dental groups?	Yes. Plans are to report decisions made by delegated entities – such as an external, contracted entity responsible for organization determinations (e.g., claims processing and pre-service decisions) or reconsiderations.
9.	The Tech Specs advise plans to exclude certain duplicate/edits when reporting on the claim denial requirement. Is the intent to exclude duplicates or is it to exclude "billing" errors or both? For example, if a claim is denied because the provider didn't submit the claim with the required modifier, should that be excluded from the count?	Plans are to report organization determinations where a substantive decision (Fully Favorable, Partially Favorable, and Adverse) has been made. Plans should exclude duplicate claim submissions (e.g., a request for payment concerning the same service) and claims returned to a provider/supplier due to error (e.g., claim submissions or forms that are incomplete, invalid or do not meet the

		requirements for a Medicare claim).
10.	Do we have to include lab claims for this measure? Do we need to report the ones which involve no pre-service as well as the ones that involve pre-service?	Yes. Plans are to report lab claims. Even in the absence of a pre-service request, a request for payment (claim) is a reportable organization determination.
11.	Please confirm the following: Scenario One Enrollee is hospitalized for heart surgery, no prior auth is required and the claim is paid timely in accordance with full benefit coverage. Not an organization determination. Our reading of the Medicare Managed Care Manual reveals that the organization is only required to notify the enrollee of Partially Favorable or Adverse decisions. There is no requirement to notify enrollees of Fully Favorable decisions.	 Scenario One Prior authorization is not required to consider a decision an organization determination. A submitted claim is a request for an organization determination. All paid claims are reportable (Fully Favorable) organization determinations. Timeframe and notification requirements for Fully Favorable determinations are described under 42 C.F.R 422.568(b) and (c). *Written* notice is required for Partially Favorable, and Adverse determinations.
12.	Please confirm the following: Scenario Two Enrollee obtains a rhinoplasty for purely cosmetic reasons, which is a clear exclusion on the policy. Enrollee and provider both know this is likely not covered but they submit the claim. Claim is denied as an exclusion/ non-covered service. Neither the enrollee nor the provider pursues it any further. Not an organizational determination.	 Scenario Two Provided rhinoplasty is not part of a plan's benefit package (i.e., rhinoplasty is a "value added" service offered outside of the plan's Medicare package), the plan is **not** to report this denial as an organization determination.
13.	Please confirm the following: Scenario Three Enrollee is out of area and in need of urgent care. Provider	 Scenario Three In this example, both the pre-service decision and

	is out of area / network. The enrollee calls plan and requests a coverage determination for this service. Health Plan approves use of out of area services. Claim is submitted and paid in full. Counted as one event (ie., pre-auth and claim not counted as two separate events) .	claim are counted as two, separate Fully Favorable organization determinations. A claim submitted for payment is an organization determination request. Claims paid in full are reportable (Fully Favorable) organization determinations.
14.	When an organization determination is extended into the future does that extension count in the reporting of org determinations (e.g. on-going approval for services approved in the initial decision)?	Yes. Plans are to count an initial request for an organization determination (request for an ongoing course of treatment) as separate from any additional requests to extend the coverage. For example, plans are to count an initial approved request for physical therapy services as one organization determination. If the plan, later, approves a subsequent request to continue the ongoing services, the plan should count the decision to extend physical therapy services as another, separate organization determination.
15.	Our interpretation is that the term "contracted provider" means "contracted with the health plan" not "contracted with Medicare".	Yes. For purposes of Part C Measure 6 reporting requirements, "contracted provider" means "contracted with the health plan" not "contracted" (or participating) with Medicare."
16.	When we make an Adverse determination that is sent to the QIO for review and later our Adverse determination is overturned, should we count and report the initial Adverse determination that goes to the QIO? We understand that QIO determinations are excluded from our reporting.	Yes. Regardless of whether a QIO overturns an Adverse organization determination, plans are to report the initial Adverse or Partially Favorable organization determination.
17.	Should cases forwarded to the Part C IRE be counted once in the measure, i.e., as the Partially Favorable or Adverse decision prior to sending to the IRE?	No. When a plan upholds its adverse or partially favorable organization determination at the reconsideration level, the plan generally must report both the adverse or partially favorable organization determination *and* reconsideration. Exceptions: Plans are not to report: 1.) Cases forwarded to the IRE for dismissal or 2.) QIO determinations

		concerning an inpatient hospital, skilled nursing facility, home health and comprehensive outpatient rehabilitation facility services terminations.
18.	Should supplemental benefit data be excluded from the Part C Reporting?	If the plan's question refers to value-added items or services (such as extra vision or eye care or a health club membership), such coverage decisions are not appealable under the Subpart M reconsideration process because they are not part of the plan's benefit package; thus, value-added supplemental data is not reportable under this effort. . However, if a plan includes a supplemental benefit (e.g., a non-Medicare covered item/service) as *part of its Medicare benefit package*, then a dispute concerning this issue is addressed under the plan's reconsideration process and the organization determination and reconsideration concerning the supplemental benefit are reportable under this effort.
19.	How should plans report reconsiderations involving a Medicare covered service/item and a non-Medicare covered service/item? Example: Medicare provides coverage for a Lift Mechanism. Medicare does not provide coverage for a Lift Chair.	If a plan provides coverage for a Lift Mechanism, but denies coverage for a Lift Chair (because Medicare does not provide coverage for a Lift Chair), the plan is to report its coverage decision as a Partially Favorable decision. Exception: If a plan opts to cover the Lift Chair, as a supplemental benefit under the plan's Medicare benefit package, then the plan is to report its coverage decision as Fully Favorable.